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Shifting sands: Actor role and identity reconfigurations in service systems

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ABSTRACT

Building on previous actor-to-actor perspectives in service systems, this study mapped the dialectic trajectory of actor role and identity transitions in the context of family caregiving. The study employed the theoretical lens of role and identity transitions and drew on in-depth, qualitative interviews with 22 unpaid family caregivers caring for dependent relatives to demonstrate how family caregiver roles and identities co-evolve throughout the caregiving journey. Our findings elucidate three dynamic reconfigurations of role and identity transitions in family caregiving. We evince how such transitions vary in both degree and type, and range from incremental to disruptive, as actors assume and detach from roles and associated identities. Theoretical contributions shed light on the emergent and nuanced nature of role and identity transitions, as roles and identities synchronously and asynchronously co-evolve in a service system in conjunction with changed relations between actors, society, and the service system. The paper concludes with implications for enhancing actor engagement in dynamic service systems.

1. Introduction

There is a growing stream of scholarship that examines the social and market actors in service systems (Finsterwalder, 2018; Vargo & Lusch, 2016). Focusing on social as opposed to non-human actors, actors are broadly defined as "humans or collections of humans – including economy and society - who are involved in the logic of human exchange systems […] and who are typically categorized according to their discrete roles" (Lusch & Vargo, 2014, p. 102). An actor-to-actor perspective recognizes actor roles as fluid and changeable (Corsaro & Mattsson, 2019). Actors are inter-defined in concrete situations (Kjellberg et al., 2019) as they enter and exit different roles (Troccoli & Felizardo, 2020). As human actors are sentient, their identities, namely "their self-meanings that define who one is," are reflected in the roles they assume (Burke, 2006, p. 81). However, such inter-relationships between identities and roles are yet to be discussed in service systems. We address this gap by examining how actor roles and associated identities co-evolve in relation to other actors in service systems in the context of family caregiving.

Role and identity changes are emblematic of numerous life transitions, such as pregnancy and motherhood (Hennekam et al., 2019; Ladge et al., 2012), adulthood (Tanti et al., 2011), and moving from foster care to independent living (Piancentini et al., 2014). Regarding non-family service systems, role and identity changes occur with career changes (Ibarra & Barbulescu, 2010), including promotion (Jonczyk et al., 2016), expatriation (Zikic & Richardson, 2016), re-entering civilian life after military life (Binks & Cambridge, 2018), and retirement (Schau et al., 2009). Consumer identity construction largely has been portrayed in the marketing literature as voluntary and goal-driven, taking place as consumers assume new roles associated with life transitions (Schau, Gilly, & Wolfinbarger, 2009; Walther & Schouten, 2016). Central to all these contexts is that change is endogenous to an actor's life trajectory, occurring to the actor him/herself.

In contrast, in family caregiving, the change is exogenous, as changes in the dependent family member or referent beneficiary affect the focal caregiver or non-referent beneficiary (Kelleher et al., 2020). The caregiver role emerges often incrementally and unnoticed as the dependent family member's care needs change, with associated impacts on caregiver identity and on informal service provision (e.g., Dean et al., 2020) in the service system. Moreover, actors have little control over the care

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needs of the dependent family member; they cannot readily divorce their personal and family identities while providing care, nor can they revoke their membership in their family. Consequently, caregiver identity is "imposed rather than self-selected" (Dean et al., 2020, p. 16). As a result, research in family caregiving has acknowledged the need to explore caregiver identity formation (Eifert et al., 2015), as it may influence caregiver willingness to accept help from other actors in the service system, which in turn supports caregiver well-being (Montgomery & Kosloski, 2013).

The contribution of unpaid family caregivers to the overall functioning of the health care systems is significant (Bookman & Harrington, 2007), and there is growing acknowledgement of the importance of informal unpaid family caregivers as key actors within health and social care systems (Von Thiele Schwarz, 2016). Driving this phenomenon is the growth of aging populations, the development of social care policies for aging persons, and changing cultural norms and practices related to home care (Mair et al., 2016).

While within families the roles and identities of family caregivers and dependents inextricably intersect, there is a paucity of research on the dynamic nature of such intersections within service systems. Using the theoretical lens of roles in service systems (Kjellberg et al., 2019; Troccoli & Felizardo, 2020) and drawing from the literature on role and identity transitions, this paper examines the intersections between actor roles and identities and associated role and identity transitions as actors engage in service systems over time. Drawing on a qualitative study of 22 family caregivers, we document the role and identity transitions experienced by family caregivers when they assume caregiving roles, with attention paid to how role change and identity transitions take place.

Overall, our research on family caregiving and informal service provision addresses recent calls to study the inter-relations between diverse actors in service systems (Brodie et al., 2019) and caregiver identity formation (Dean et al., 2020; Sartirana et al., 2019) by making three important contributions. First, we highlight that role changes can take place *within* as well as *between* roles in service system, and in turn such role changes can precipitate synchronous and asynchronous identity changes. Second, role changes and associated identity transitioning can be difficult, even traumatic, especially during disruptive, unanticipated transitions that are non-volitional. Third, role and identity transitions evince both incremental and disruptive role changes, which precipitate further role changes for other actors and impact resource integration within the service system. In the sections that follow, we review the literature on roles and identity in service systems and family caregiving, describe the research design, discuss the findings, and develop theoretical contributions. We conclude the paper with implications for academics and practitioners.

2. Literature review

2.1. Actor role and identity in service systems

A service system is defined as a "dynamic value-cocreation configuration of resources, including people, organizations, shared information (language, laws, measures, methods), and technology" consisting of interacting entities (Maglio et al., 2009, p. 399). Two such interconnected service systems are the family and health care systems. In recent years, service research has expanded beyond dyadic relations between actors with fixed roles, such as customer and firm, to acknowledge that actor roles are multiple, fluid, and inter-defined (Ekman et al., 2016; Kjellberg et al., 2019; Vargo & Lusch, 2011). These multiple and complex social and organizational roles are relevant in family caring, as caregivers are also family members, consumers, and service providers.

In general, roles act as social prescriptions for behavior (Sveningsson & Alvesson, 2003), including the rights and responsibilities that are perceived to be embedded in the role (Fischer & Arnold, 1994). More recently, Methot et al. (2018, p. 729) noted that roles within social systems combine "patterned and appropriate social behaviors, identities internalized by social participants, and scripts and expectations associated by role occupants." Such socially constructed roles (Solomon et al., 1985) guide actors' behavior in service systems, as roles and identities are subjectively, as well as inter-subjectively, experienced, in conjunction with other actors (Levitan et al., 2018), and as actors negotiate the pertinent institutional logics of the system (see Vargo & Lusch, 2016).

While actor roles in service systems are based on common scripts that set the expectations for behavior (Troccoli & Felizardo, 2020), Service-Dominant (SD) logic points out that roles may also be non-scripted (Kjellberg et al., 2019). As actor roles in service systems are dynamic and multiple, they can act as "vehicles that mediate and negotiate the meanings constructed in relational interactions," while actor roles themselves are subject to ongoing reconstruction through relational processes (Simpson & Carroll, 2008, p. 43).

In addressing the links between roles and identity, Burke (2006) noted that roles are based on behavioral expectations, while identity refers to self-meanings. In service systems, actors occupy multiple roles (e.g., daughter, wife, father, caregiver) and hold group (e.g., family, subcultural, professional) and personal (sense of self) identities (Levitan et al., 2018) simultaneously. This means that identity is crafted from a complex nexus of role commitments in ways that incorporate both a self-reflexive dimension based on the actor's own narrative (Burke, 2006) and a related social dimension that is acknowledged and supported in interacting with others (Eifert et al., 2015). Importantly, identity emerges through role performance and develops through interactions with others, thus precipitating role and identity transitions.

2.2. Role and identity transitions in service systems

The concept of role and identity transitions has received much attention in organizational (e.g., Ashforth et al., 2000; Ladge et al., 2012), consumer (e.g., Maldonado & Tansuhaj, 1999; Schau et al., 2009; Walther & Schouten, 2016), and caregiving (Dean et al., 2020; Piancentini et al., 2014) contexts. In organizational settings, identity is directly and inextricably shaped by role transitions that involve boundary-crossing activities, as individuals enter and exit multiple roles, e.g., jobs, promotion, retirement, secondment (Ashforth, 2001). As roles are integral to ongoing identity reconstruction (Simpson & Carroll, 2008), changes in assumed roles can trigger identity changes. Further, as roles and identities co-evolve over time, the associated transitions may be gradual and processual or abrupt and disruptive in nature.

In consumer research, the predominant focus has been on consumers' conscious identity projects. Within this body of work, identity changes are typically viewed as positive and intrinsically related to life transitions, as agentic consumers seek experiences that support their identity reconstruction. For example, in their study of women's erotic consumption, Walther and Schouten (2016, p. 281) characterized the consumer as "the chief architect and the obligatory point of passage for the myriad human, material and discursive actors that contribute to self-construction and understanding," for whom other actors (e.g., men) appear as mere instruments for achieving pleasure. In another study of retirees, Schau et al. (2009) described how retirees draw on past identities for inspiration but optimistically move forward in maintaining "an identity project through accommodation that is central for them" (p. 272).

In contrast, in taking on the family caregiving role, the process of identity change is often involuntary, ambivalent, and subliminal. Dean et al. (2020) described role entry into caregiving as liminal. Drawing on Turner's (1974) work in emphasizing uncertainty, the scholars highlighted the tensions experienced by leaving behind a former identity and the ensuing resentment in feeling trapped by the burden of caregiving.

Occupying the caregiver role can take several forms and may vary from providing circumscribed, bounded assistance and support with routine housework and financial tasks to sporadic, unpredictable, and

emotionally traumatic care episodes (Corbin & Strauss, 1985). Further, as the family caregiver role requires undertaking new types of activities (Dean et al., 2020), family caregivers need to constantly accommodate their role and identity as a family member with their role and identity as a caregiver. Specifically, family caregivers simultaneously retain their family position as spouse, parent, or sibling while adopting the family caregiver role. In this sense, caregivers may view caring for family members as part of the institutional logic of their particular family system, leading them to resist the "bureaucratisation" of their "natural" family role and relationships (Burr et al., 1979). Conversely, family caregivers may not self-identify with the caregiving role or be readily identified as a caregiver by others. Wittingly or unwittingly, the "caregiving role affects the identity of each person that assumes the role" (Montgomery & Kosloski, 2013, p. 136).

In addition, caregiving may involve a mix of paid and informal interactions between actors, in addition to the ensemble of family and friends who assist and deliver care (Barnhart & Penaloza, 2013; Kelleher et al., 2020). As such, role and identity change necessitates the consideration of a multiplicity of interests, including those of dependent family member(s), and relations between family members and other actors in the wider service system. In some cases, caregivers support health care providers by monitoring family members' treatment and performing other clinical tasks at home (Quah, 2014), such as identifying symptoms and supporting diagnosis, treatment, and post-treatment in recovery, relapse, and/or death. In other cases, caregiving extends beyond the home and involves supporting professional health care within residential-care settings (O'Keefe & Fancey, 2000).

Eifert et al. (2015) noted that role transitions act as a catalyst for the development of an evolving family caregiver identity. Accordingly, changes in the caregiving context may prompt identity change. For example, the deteriorating condition of the cared for may lead to conflicts between multiple identities or may force the caregiver to behave in ways that are incongruent with their identity expectations (Montgomery & Kosloski, 2013). In extreme cases, the caregiver role can engulf or replace other roles and become a master identity, narrowing the opportunities for other roles and identities to co-exist (Eifert et al., 2015), at least until the care stops. Of interest in this work is documenting the contours and dynamics of role and identity transitions for caregivers. We next present our research design.

3. Method

In developing the empirical research objective to explore the experiences of family caregivers in caring for a dependent family member, the third author worked with permission from three caregiver associations. The research objective aligned with the associations' mandates to develop supports for diverse, new, long-term, and former caregivers. Following university ethics approval, she posted an invitation in the caregiver associations' monthly newsletters explaining the purpose of the research and calling for volunteers to participate. The caregiver associations facilitated and supported the voluntary participation of their members. Subsequently, snowballing was used to identify additional caregiver participants. Participant contexts ranged from providing care for parents, spouses, and adult children suffering from physical and psychological illnesses, including stroke, Alzheimer's disease, and cancer.

Regarding data collection, the third author employed a contextually oriented approach to interviewing (Levitan et al., 2018, p. 1) to access the roles and identity experiences of family caregivers. Informal, face-to-face, loosely structured in-depth interviews (Denzin & Lincoln, 1994) were conducted with 22 caregivers (12 women and 10 men) in places and at times convenient to them (see Table 1 for a profile of informants). All informants were given pseudonyms to ensure confidentiality. During the interviews, participants recounted, in their own words, how they became a family caregiver and shared perceptions and experiences of caregiving important to them (McCracken, 1988). Deeper questions followed about how they saw themselves now and how this compared to before becoming a caregiver, as well as how being a caregiver impacted their other roles and identities within their nuclear and extended family. Every effort was made to ensure that the discussion flowed like a conversation. Earlier topics were revisited at natural pause points during the interview to gain depth and fill gaps (Lincoln & Guba, 1985), using the loosely structured interview protocol as a source of natural and less intrusive prompts (McCracken, 1988). The interviews lasted between 60 and 120 min and were conducted, recorded, and fully transcribed by the third author. Immediately after each interview, reflections and observations were recorded, including interviewer emotions and sentiments and those she observed in participants. Transcriptions of these memos supplemented each transcript in aiding subsequent data analysis by all four authors.

Collectively, analysis employed a constant comparison approach

Table 1
Profiles of the Interview Participants.

Interviewee	Gender	Family Caring Context
Bernard	Male	Single. Gave up job to care for his father, who lives in a nursing home.
Dorothy	Female	Cared for her husband in their own home, frequently assisted by her adult son, who is married, has children, and lives in his own house.
Felicity	Female	Lives with partner. Moved back to family home to care for mother. Also cared at home for father, who has died.
Ferdinand	Male	Separated father. Lives with another family, who rents his home. Cares for adult son, who has mental health difficulties and is transitioning to independent residence.
Francesca	Female	Cares for her husband, who is in long-term care. Married, with adult children.
Georgina	Female	Cares for her daughter, who has profound physical and mental disabilities. Married, with children.
Hilda	Female	Lives with partner. Cared for her sister in her sister's home but did not live there. Sister was also cared for by her husband and daughter.
Ian	Male	Single. Cared for father.
Kurt	Male	Cared for wife, who has dementia, at home. No children or other family assistance. Wife now living in a care home.
Lucinda	Female	Cares for mother, who has dementia, and father, who had a stroke. Moved back to original family home with her partner and teenage son.
Meghan	Female	Cared for mother at home. Diagnosed with Alzheimer's, her mother moved near Meghan, husband and teenage children, and later moved in with them.
Mitchell	Male	Single. Cared for mother in original family home, where he has lived all his life. Sister assisted some weekends. Brother not involved.
Noreen	Female	Cared for mother in her home shared with husband and adult children and then in a residential home.
Oran	Male	Married, with children. Actively involved with brother in care for mother, who lives in a residential home near the other son. Visits regularly.
Rita	Female	Cared for widowed mother in the family home. One married brother, who was also involved in caregiving. After mother's death, cared for her elderly bachelor uncle, who lived alone and has died.
Ruby	Female	Cared for her husband in their home. No children or other family members involved.
Sabrina	Female	Married, no children. Cared for her younger sister, who had Down syndrome, all her life. Also cared for her bachelor brother in his home and hospital.
Sylvian	Male	Divorced. Cared for mother, then cared for elderly neighbour.
Timothy	Male	Lives with wife and adult daughter. Cared for his father in his father's own home.
Trevor	Male	Cared for father and then his mother in the family home.
Triona	Female	Cared for her father and now cares for her mother, who lives in her own home more than two hours away. Mother also spends long periods living with Triona, husband and teenage daughters.
Vincent	Male	Single. Cared for mother in original family home. Two brothers living abroad.

(Glaser, 1965) and followed Spiggle's (1994) guidelines for interpreting qualitative data. The objective of the analysis was to understand participants' experiences of the caregiver role, specifically how they viewed themselves and their identity in that role. Initially, the data were categorized temporally, namely by the experiences of becoming a caregiver, being a caregiver, and ceasing to care for the family member. Next, higher-order codes were abstracted regarding details of role and identity transitions experienced by different caregivers over time during different phases of the family member's illness or condition. Subsequent dimensionalization (Spiggle, 1994) entailed further analysis of the properties of each role/identity transition, resulting in the derivation of the three categories of *Role Entry – Identity Adjustment, Role Distribution – Identity Reassessment, and Role Dissolution – Identity Reformation*. The final phase of data analysis, integration (Spiggle, 1994), involved all four authors discussing and relating the findings to extant theory in the literature. In addition, the third author performed member checks, discussing the emergent findings with representatives from the three caregiver associations and with a sample of participants. These discussions enhanced collective understanding of caregivers' experiences and challenges, as well as the co-creation of a dissemination plan, and helped the research team develop implications for service systems. The next section presents the findings.

4. Findings

4.1. Reconfigurations: Role and identity transitions in service systems

In caregiving, caregivers' roles and identities synchronously and asynchronously co-evolve as they deal with gradual or sudden illness and related increases and decreases in the dependency of family members on their care until caregiving ends (see Fig. 1). Three major role and identity transitions along the caregiving journey are represented along the sides of the triangle in Fig. 1. We use the term "reconfiguration" to describe the co-evolution of roles and identities as the responsibilities, tasks, and relationships are restructured among the caregiver, the cared for, and the broader service system. The three *reconfigurations* include *Role Entry –Identity Adjustment, Role Redistribution – Identity Reassessment,* and *Role Dissolution – Identity Reformation.*

4.1.1. Role Entry – Identity Adjustment

Role Entry begins when an actor enters a new role. For family caregivers, this typically begins when a family member's health deteriorates. The associated accommodation of a new identity in the form of *Identity Adjustment* displays synchronous and/or asynchronous features. Some participants reported limited conscious awareness of the increasing levels of care that they were providing the dependent family member. As Noreen explained, "*I didn't decide to become a caregiver. I just woke up one day, and I had been a caregiver 14 years, and my life was gone*." Like some daughters, Noreen's caregiving role appeared more normatively assumed according to institutional logics, rather than explicitly chosen (Phipps et al., 2003), and is consistent with research noting that family members may drift into caregiving (Dobrof & Ebenstein, 2003). Further, while her performance of the caregiver role appeared consistent with what Eifert et al. (2015) termed a "master identity," her gradual and unconscious absorption of the role undermined her ability to adjust to this master identity in the long term.

In contrast, some participants found themselves rather suddenly cast into the role of family caregiver, which completely up-ended family roles and relationships and directly affected their ability to adjust their identity. Triona reported such role immersion when her mother suddenly developed Alzheimer's and became dependent on her care. She experienced additional tension within the family system when dealing with her siblings, while caring for their previously independent mother, as she notes below.

> *It was just a whirlwind because we just did not know what was happening after. We did not know how to deal with it (mother's Alzheimer's diagnosis and care requirements). We didn't know what to expect from it. My sister and brother… They didn't think that Mom needed the help that she did. I don't know whether they were in denial about what was actually going on. My mother had always been such an independent woman.* (Triona).

Whereas previous accounts of identity transformation have emphasized consumers' consciously driven projects (Schau et al., 2009; Walther & Schouten, 2016), our findings detail gradual to abrupt identity transition that is triggered by an unplanned and disruptive incorporation of the caregiver role. Further, when role change is abrupt, and the associated identity adjustment is gradual, as in Noreen's case, the role transition often remains invisible to other family members and to those outside the caregiver's family. This contrasts with more abrupt role changes, as experienced by Triona, which require intense activity yet can also temper conscious role adaptation and reflexive identity.

In adjusting their identity to the new caregiver role, some family caregivers experienced a disassociation from their other previous roles

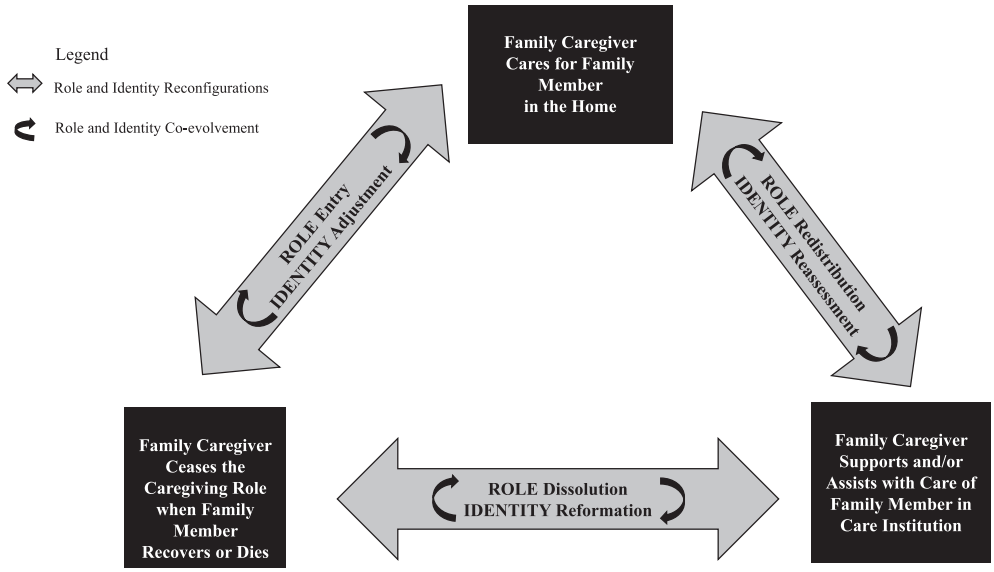

Fig. 1. Actor Role and Identity Reconfigurations in Service Systems: The Case of Family Caregiving.

and identities within and beyond the family. For example, Francesca's relationship with her husband was significantly altered when he suffered a stroke, and she became his primary caregiver. Reflecting on her struggle, Francesca poignantly described the loss of her previous identity as a wife and her marital relationship as a type of social death:

> *You don't see yourself as a bereaved person, but actually, you are. Some days, you get frustrated. You are looking at him: "that's not my husband; that's a lovely man whom I'm minding. That's not my husband" … He's not your partner anymore, someone you can turn to. He's not the person that you can ask advice from. He's not the fellow that comes home in the evening to give you a hug.* (Francesca)

Our findings point to a loss of identity in the changed roles and resulting imbalance in relationships within the caregiver–care receiver dyad. In the passage above, Francesca experienced difficulties adjusting to being a caregiver while maintaining her identity as wife when her husband could no longer fulfill his role as husband. In another, similar case, Kurt struggled to adjust to the caregiver role, as this was associated with the loss of his identity as husband and his relationship with his wife, who no longer recognized him. This overwhelmed him to the degree that he rejected the prospect of any future caregiving roles in the future:

> *To be brutally frank, I wish she [wife] would go … I have had enough. I don't even want to keep a bloody cat. I don't want to be responsible for anything ever again. I have been there and done it. I just want to get in the car and go on holiday maybe. I care, I really do. I look after the bloody woman but ….* (Kurt)

Hence, the significance of the reconfiguration associated with the role transition from parent, child, or husband/wife to caregiver, and adjustment to the latter identity, led to frustration, conflict, and a deep sense of loss, akin to bereavement. Reflecting the recursive nature of role and identity change, a significant change in role and associated identity transition impacts how actors approach their roles and associated relations with other actors, both present and future.

4.1.2. Role redistribution – identity reassessment

During *Role Redistribution – Identity Reassessment*, the family caregiver is joined by health care professionals and external actors outside of the family to share the caregiving role. Importantly, role redistribution is triggered by the change in the nature and location of family caregiving, and this modification of roles is accompanied by a reassessment of identity. For example, when Bernard's father's health deteriorated and he had to move into a residential nursing home, Bernard continued to visit him daily and to care for him. Although the formal caregiver role ceased, Bernard remained an important part of the service system:

> *Of course you are still busy, because Dad is high maintenance. We're up and down to the nursing home every day anyway. Either me or my mother. We're still kind of very busy with it.* (Bernard)

When the increasingly dependent family member moves into a residential care home, and care is primarily provided by nurses, doctors, and paid care workers, the family caregiver experiences role redistribution. As with Bernard, several participants modified their previous caregiver role by continuing to actively monitor their relatives' professional care. They reported stepping in as care needs arose in the facilities. This included feeding or administering medicine to relatives and engaging in the wider health care service system in order to ease the care work of formal caregivers. Although we focus on identity transitions, our findings regarding caregiving role changes are consistent with O'Keefe & Fancy's (2000) findings that family caregivers continue to take some responsibility for family members' care in residential-care settings.

While the relocation of care from the home to an institutional setting reduced direct responsibility and worry, role redistribution brought about a sense of separation and loss from the previous family-caregiver identity:

> *The nursing home was a big change, you know, after this caregiving role. It is like when a child goes to school, the things you have been doing. You think, "Great, I will have time to myself." But your role is gone in that way, which is half a relief. You know, that is what I was doing, that is what I was skilled at. I suppose you miss it in a way.* (Meghan)

While in many cases the ill family member remained in full-time institutional care, in some cases the dependent family member returned home after a short period of respite care or when an illness went into remission. Even a short period of respite took its toll on both the family caregiver and those cared for, with both struggling to cope with being separated. Such struggles demonstrate the relationship ties that bind actors together:

> *My mother went in to respite and I cried my eyes out for 48 h. She didn't settle for 48 h. I didn't settle for 48 h. I think we were so tied together mentally and physically*. (Mitchell)

During role redistribution and identity reassessment, the roles and identities of both caregivers and their loved ones were destabilized substantially. In Mitchell's experience of caring for his mother, for example, we observed an entwinement of the roles and identities involving deeply valued interactions and relational meanings between the caregiver and dependent family member that were central to Mitchell's identity as a dutiful son. Several participants reported struggling with the absence of the person they had cared for, and they had difficulty reassessing their identity during role redistribution.

4.1.3. Role dissolution – identity reformation

Role Dissolution and Identity Reformation marks the final reconfiguration. At this point, the caregiving role ceases to exist due to the ill relative passing away or recovering, and a new identity is then (re) constructed. For some caregivers, role dissolution was abrupt, and with it, the resultant effect on identity was unanticipated and difficult. For other family caregivers, even those whose loved ones had endured long illnesses, and who therefore could prepare for their eventual demise, transitioning to the role of former family caregiver was very traumatic. Concerns with their own mortality added to the difficult identity transition for some caregivers whose relatives had passed away. Below, Vincent expresses his deep sense of loss of role and purpose, leaving him wondering about who he is:

> *Maybe I missed it (caregiving) more after, as you become so consumed by it. There is certainly a sense of loss when it ends, a feeling that there is something missing in my life now. You certainly feel, "Oh, my God, am I next? If I have nothing to do now, do I suddenly become the person that she was?*" (Vincent)

Role dissolution resulted in destabilization and the loss of caregiver identity and status in the broader health care service system. In his interview, Trevor noted this loss of social recognition, which exacerbated the difficult transition in losing the caregiving role and identity:

> *The 25 years that I looked after my mum and dad is not categorized as work. I lost my identity. I was my parents' caregiver – that was my identity. Mum and dad, they were the center of my world. They were the sun that I went around. It's very hard to readapt, to get back to your own personality. When one ceases caring, the door is slammed against you. Your former contribution is not recognized.* (Trevor)

Transitioning to the role of former caregiver sometimes precipitated greater self-awareness and self-understanding, similar to what Ibarra and Barbulescu (2010) noted in work-related role and identity transitions. And yet, the nature of family and end of life added intensity beyond many work situations due to the self-reflection and reassessment of shifting family roles, relationships, and identities.

Despite the loss of identity experienced when the caregiving role

ceased, as expressed by Vincent and Trevor, there is an opportunity for other roles and identities to emerge. Ruby, for example, revealed that although she did not know what future roles or identities lay ahead, she expressed an optimistic outlook and acceptance of a changed future that helped her transition:

> *You are moving on to something else, and I suppose you have to think of the chrysalis, the moth and the butterfly and everything. And who knows? Sometimes, after what seems to be a pretty dire situation, you can get wonderful wings after it. You know, I am just hoping that will be the case. A day at a time really. … It is not that I am expecting to meet anybody else, but I know there could be huge other things ahead of me.* (Ruby)

For other participants dealing with role dissolution, some form of mourning and/or personal reinvention helped them move forward. Taking the next steps required effort and support to construct a new role and identity or to reconstruct previous role(s) and identity(ies). Optimism and mourning indicate the range in which role dissolution is experienced and again underline the continuous recursive nature of role and identity change.

5. Discussion

Our discussion interrogates the intersections between actor roles and identities, and associated transitions in family and social care systems, using family caregiving as a particular context to theorize about service systems more generally.

First, we highlight that role changes can take place *within* as well as *between* roles and, in turn, precipitate synchronous and asynchronous identity changes in a service system. By delineating three pivotal role and identity transitions, *Role Entry – Identity Adjustment, Role Redistribution – Identity Reassessment,* and *Role Dissolution – Identity Reformation,* we reveal key temporal-spatial points at which family caregivers enter, adapt to, accommodate, and exit new and overlapping roles that result in identity reconfiguration. Role redistribution means that the caregiver needs to engage in a broader (or narrower) set of tasks associated with a role as, for example, the cared for deteriorates (improves) and the role expands (diminishes). Sometimes, role redistribution involves continuing the caregiving role, even after it is no longer formally recognized in the service system. For example, a caregiver loses his/her formal and social caregiver role within the service system when the cared for enters a home, but the caregiver continues to perform the caregiver role unofficially as caregiving is shared with formal caregivers. This means that a role could ostensibly change or cease but the required tasks and performance of the role, while unacknowledged, persist. This liminal state necessitates ongoing identity readjustment and reassessment, revealing that role and identity changes do not always occur synchronously or indeed successfully. Rather, actor roles and associated identity changes could be lagged, stalled, incomplete, or unsuccessful. Building on previous work that focuses on actor roles (Kjellberg et al., 2019), role transition (e.g., Burr et al., 1979), and identity transitions (e.g., Ladge et al., 2012) separately, we note changes *within* as well as *between* roles and detail how these role changes precipitate synchronous and asynchronous identity transitions in service systems, thus contributing a more comprehensive understanding of intersecting roles and identities in service systems.

Second, in building on previous research that has shown actors and roles to be fluid, inter-defined, and inter-changeable in service systems (Kjellberg et al., 2019), our findings show that for human actors, assuming and performing the caregiving role is often quite burdensome and enduring, especially during unanticipated, disruptive, and non-volitional transitions. According to our findings, caregivers experience significant financial, physical, and psychological consequences and are frequently not supported by the system that benefits from their unpaid work. In many ways, the lack of acknowledgement and deliberate invisibility of the unpaid caregiver role within the system allows social care providers and non-participating family members to abdicate their caregiving responsibilities. The problematic role transitions highlighted in our study stand in marked contrast with the aspirational role transitions studied within consumer research (Schau et al., 2009), which emphasize volitional identity projects. To detail, our study presents family caregiving as a potential form of temporal and familial entrapment comprising involuntary, unconscious role imposition and problematic and resistant identity adjustment. We further reveal the uncomfortable liminality experienced following role dissolution upon cessation of the caregiving role. Extending Dean et al.'s (2020) observation of the need to support caregivers experiencing feelings of alienation when entering the caregiver role, we highlight the importance of supporting caregivers throughout the entire caregiving journey, not just at the beginning, to enable a successful post-care transition and identity reformation. We add that self-reflection, personal goal-setting, and gradual role reconfiguration are part of this ultimate identity reformation for some caregivers. Also helpful following dissolution of the caregiver role is an openness to rebuilding social networks and a renewed focus on self-care and staying active. Interestingly, in the post-care phase, the lagged nature of role transition and associated identity change can be quite pronounced. For some, the identity of former caregiver becomes the new master identity, while it is renounced by others as actors move on with their lives post-caregiving, e.g., marrying again, returning to work or education, or retiring.

Third, our findings regarding role and identity transitions evince a range of incremental to disruptive role changes that precipitate further role and identity transitions for other actors and that ultimately impact resource integration within the service system. We describe this as a domino effect. Due to the inter-defined and interdependent nature of roles in a service system (Kjellberg et al., 2019), when a focal actor requires more temporal, material, and/or psychological resources, others within that system adjust to maintain its stasis. In our case, the caregivers initially increased their efforts in addressing the health care needs of the dependent family member. Due to the inter-defined and interdependent nature of roles, when a focal actor requires more temporal, material and/or psychological resources due to growing care needs within the service system, other actors within the system need to adjust. For incremental changes, other actor(s) may increase their resource allocation gradually and unconsciously, which potentially affects their identity and well-being and can compromise the viability of the service system as well. For example, during the *Role Entry – Identity Adjustment* reconfiguration, some family members "drifted" into the role of caregiver as a "normalized" extension of the family member role. This member was often the person who first became aware of or accepted the deteriorating health of a family member, particularly when other actors within the family or service system did not agree. Consequently, the caregiver role fell onto one person because other actors within the (family) system would not assume that role. In generating insight into the range of incremental to disruptive role changes and identity transitions, and the associated and enduring consequences for the caregiver and related actors, we contribute to the understanding of resource dynamics within the service system overall.

6. Summary and future research directions

Overall, our findings contribute to a deeper understanding of the nature of role and identity intersections and transitions in family caregiving and service systems. And yet there is much more work to be done. First, the identity and role reconfigurations elucidated in this study might provide researchers with a valuable frame within which to re-examine actor engagement, in building on Brodie et al. (2019). Our study offers some preliminary evidence that role and identity reconfigurations shape actors' dispositions to engage with a service system by providing motivation and direction. Second, it would be useful to explore identity and role transitions in the context of transformative service research (Anderson et al., 2013). Such work might provide

insights and strategic interventions for service providers to facilitate role and identity transitions, thus supporting uplifting changes in caregivers' lives, with positive ripple effects in the care and lives of family members. Supporting Lopez Hartmann et al. (2012) and Holt Clemmensen et al. (2020), we emphasize the importance of mapping role and identity transitions in order to optimally design support care packages that are specifically timed and tailored to caregiver needs. Third, we encourage further work on asynchronous and synchronous role and identity changes in other contexts, such as succession in family businesses, transitions in job and leadership roles and identities following a company's acquisition or merger, and students' relationships with supervisors and lecturers after graduation.

We note that the current situation with COVID-19 has presented a dramatic disruption, requiring numerous role and identity transitions within families, as well as in health care and other service systems. It is our hope that our work has shed light on some of the role reconfigurations and related identity transitions. We encourage further work at meso and micro levels in charting the obstacles facing actors and the rewards they garner in navigating fluctuating and overlapping roles and multiple identity commitments. At a macro system level, we encourage further work that will explore role and identity transitions and reconfigurations in order to provide solutions that will enhance the work and well-being of the actors engaged in service systems, as well as those who benefit.

Finally, while our work has focused on human actors in the service system of family caregiving, we encourage further work on relations among humans and material and smart technology, as consistent with work on SD logic. As an example of the extension of these role and identity transitions in a broadened actor-to-actor view in the health care system, we note Čaić et al.'s (2019) observation that robots influence the roles of caregivers and those cared for. Extending from their work, we suggest that while role redistribution occurs for non-human actors who provide care, such as socially assisting robots or digital personal assistants (e.g., Alexa), there is—as of yet—no associated identity transition for the non-sentient caregiving robot. However, the identity of the care receiver and other caregivers in the family may well become altered. Similar biomedical contexts, such as patients' gradual return to wellness with prosthetic limbs or pacemakers, pose fruitful avenues for further research. More broadly, technical developments in other service sectors, such as robots and algorithms in finance, logistics, and human resources, likely trigger role and identity transitions and reverberate in the interfaces of human and non-human actors. The actor role and identity transitions stimulated by technological applications in these and other service sectors represent fruitful and challenging future avenues for research that will advance actor well-being and service system vitality.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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